Medicaid and Medicare Plan Enrollment for Dually Eligible Beneficiaries

Medicaid and Medicare together provide coverage of medical care and long-term services and supports (LTSS) for approximately 10 million low-income seniors and people with disabilities who are dually eligible for both programs. These individuals are among the poorest and sickest individuals covered by either program, and account for a disproportionate share of Medicaid and Medicare spending (MedPAC and MACPAC 2016).

Together, the two programs provide a comprehensive set of benefits. Medicare is the primary payer for services such as physician visits, hospital stays, post-acute skilled care, and prescription drugs. Medicaid wraps around Medicare's coverage by paying Medicare premiums and cost sharing, as well as covering additional benefits not covered by Medicare, such as LTSS. Nevertheless, policymakers have long-standing concerns around the lack of coordination between Medicaid and Medicare, and how this can result in fragmented care, high costs, and poor outcomes.

In practice, the experience of dually eligible beneficiaries is more complex than having coverage from both Medicaid and Medicare. Both programs deliver services through fee for service (FFS) and managed care, and many beneficiaries receive services under both arrangements. For Medicaid services, many enrollees are enrolled in both a comprehensive plan for most medical services and a limited-benefit plan that provides oral health, behavioral health (including mental health and substance use services), LTSS, or transportation services. Each of these plans has its own set of providers, covered benefits, and processes that beneficiaries must understand and navigate.[1] Understanding which Medicaid and Medicare plans dually eligible beneficiaries enroll in may be useful in thinking about how to improve integration of services and administrative alignment between Medicaid and Medicare.

This issue brief focuses on plan enrollment for full-benefit dually eligible beneficiaries, finding that many beneficiaries are enrolled in three or more plans. The brief also examines enrollment specific to limited-benefit Medicaid managed care, finding that almost half of dually eligible beneficiaries are enrolled in at least one such plan. Moreover, while a special type of plan known as Dual-eligible Special Needs Plans (D-SNPs) is designed specifically to integrate care between Medicaid and Medicare, about 60 percent of D-SNP enrollees also have a limited-benefit plan.

Our analysis uses data from 2011, the most recent year for which data are available. Partial benefit dually eligible beneficiaries are excluded from the analysis.[2] A description of the available data sources for dually eligible beneficiaries' enrollment in Medicaid and Medicare can be found in the appendix.

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Delivery of Medicaid Services for Dually Eligible Beneficiaries

States may deliver Medicaid benefits to enrollees on a FFS basis, through managed care, or both. Under FFS, the state pays providers directly for each covered service that the beneficiary receives. In 2011, about 46 percent of full-benefit dually eligible beneficiaries received their Medicaid benefits through FFS.

Under managed care, the state contracts with a health plan that is paid a fixed monthly amount per person. In turn, the plan pays providers for services included in the plan's contract with the state. Plans are at financial risk if spending exceeds the capitated payments; conversely, they are permitted to retain any portion of payments not expended for covered services and other contractually required activities. Plans may be comprehensive, covering all Medicaid services for enrollees, or they may cover only certain benefits, typically requiring a specialized network of providers.

Delivery of Medicare services for dually eligible beneficiaries

Dually eligible beneficiaries may receive Medicare coverage through Medicare FFS (Parts A and B), Medicare Advantage (the managed care component of Medicare), and Part D (prescription drugs). The Program of All-Inclusive Care for the Elderly (PACE) is a separate program that replaces traditional Medicare coverage and provides comprehensive medical and social services to certain elderly enrollees (Box 1).

BOX 1. Description of Medicare Coverage for Dually Eligible Beneficiaries

- **Medicare fee-for-service (FFS)—**also called traditional Medicare or original Medicare—consists of Part A and Part B. Part A covers inpatient hospitalizations, home health, skilled nursing facility services, and hospice care. Part B covers outpatient visits, preventive care, X-rays, and durable medical equipment.
- **Medicare Advantage plans** (sometimes referred to as Part C) are managed care plans offered by private health insurance companies approved by the Medicare program. These plans cover all Medicare Part A and B benefits, and with certain exceptions, enrollees of these plans must obtain their Part D (drug) coverage through the plan.
- **Special needs plan (SNP)** is a Medicare Advantage plan designed to target care and limit enrollment to individuals with special needs such as dually eligible beneficiaries. There are several types of SNPs:
    - **Dual-eligible special needs plans (D-SNPs)** must provide a coordinated Medicaid and Medicare benefit package that offers more integrated care than regular Medicare Advantage plans or Medicare FFS. D-SNPs must have a contract with the state Medicaid agency to provide Medicaid benefits or must arrange for benefits to be provided.[3]
    - **Chronic condition special needs plans (C-SNPs)** are limited to individuals with specific severe or disabling chronic conditions.
    - **Institutional special needs plans (I-SNPs)** which are limited to individuals who, for 90 days or longer, have needed or are expected to need the level of services provided in an institutional setting (CMS 2016a, CMS 2016b, CMS 2016c).
- **Medicare Part D** covers prescription drugs for virtually all Medicare enrollees. Full-benefit dually eligible beneficiaries are covered under the Part D Low Income Subsidy (LIS) program, which helps pay Medicare Part D premiums and cost sharing.
- **Program of All-Inclusive Care for the Elderly (PACE)** provides comprehensive medical and social services designed to help beneficiaries stay in the community. PACE is a Medicare program but states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit (CMS 2016d).

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Enrollment by Medicaid and Medicare Plan

In 2011, there were about 8 million full-benefit dually eligible beneficiaries (Table 1). Most full-benefit dually eligible beneficiaries (about 75 percent) received their Medicare-covered services through FFS in 2011. Of those beneficiaries, about 47 percent had Medicaid coverage through at least one limited-benefit plan.

Approximately 1.2 million full-benefit dually eligible beneficiaries, or about 15 percent of all enrollees, were enrolled in a Medicare Advantage plan other than a SNP. D-SNPs were the third largest enrollment category but only accounted for about 9 percent of enrollment for full-benefit dually eligible beneficiaries. Although D-SNPs were designed to coordinate benefits for enrollees, more than half (60 percent) of D-SNP enrollees had a limited-benefit plan for their Medicaid coverage. In fact, more individuals enrolled in a D-SNP had a limited-benefit Medicaid plan (60 percent) than enrollees in Medicare FFS (47 percent).

Table 1. Full-Benefit Dually Eligible Beneficiary Enrollment, 2011

Medicare	Medicaid								Total enrollment	Percent of total
	No comprehensive Medicaid managed care				Comprehensive Medicaid managed care					
	Medicaid FFS only[1]	Percent of total	Any limited-benefit managed care[2]	Percent of total	CMC only	Percent of total	CMC and limited-benefit[3]	Percent of total		
Total	3,667,575	46%	2,909,213	36%	390,416	5%	1,042,788	13%	8,009,992	100%
FFS	3,030,334	50	2,215,405	37	159,365	3	621,774	10	6,026,878	75
Medicare Advantage[4]	412,810	35	414,323	35	121,973	10	227,503	19	1,176,609	15
D-SNP	183,645	25	245,792	34	107,969	15	191,233	26	728,639	9
I-SNP	30,751	72	11,175	26	153	0	813	2	42,892	1
C-SNP	10,035	29	22,518	64	956	3	1,465	4	34,974	0

Notes: CMC is comprehensive Medicaid managed care. D-SNP is dual-eligible special needs plan. C-SNP is chronic condition special needs plan. I-SNP is institutional special needs plan. FFS is fee for service. Individuals enrolled in a Section 1876 cost plan, an employer or union sponsored Part D retiree plan, a continuing care retirement community demonstration, an end-stage renal disease managed care demonstration, or who have missing or unknown Medicaid or Medicare enrollment are not included in the table.[4] Dually eligible individuals included within this analysis are those with at least one month of dually eligible enrollment during the year, which is referred to as an ever-enrolled count. Partial-benefit dually eligible beneficiaries are excluded along with enrollees in the Program of All-Inclusive Care for the Elderly. Enrollment in Medicare Part D is not depicted in this table but Part D is a source of prescription drug coverage for full-benefit dually eligible beneficiaries. Enrollment in the territories is not included.
[1] Includes enrollees in Medicaid primary care case management.
[2] Does not include beneficiaries with both a comprehensive and a limited-benefit Medicaid managed care plan.
[3] Limited-benefit Medicaid managed care refers to plans that only cover a specific type of benefit, such as oral health, behavioral health, LTSS, or transportation. Data reflects enrollment in at least one limited-benefit plan.
[4] Medicare Advantage plans shown here include coordinated care plans (i.e., health maintenance organizations, and regional and local preferred provider organizations), Medicare Advantage private FFS plans, and Medicare medical savings account plans.
Source: Acumen LLC analysis of Medicaid and Medicare enrollment and claims data for MACPAC.

Enrollment in Limited-Benefit Medicaid Managed Care

In 2011, approximately 4.4 million full-benefit dually eligible beneficiaries were enrolled in at least one limited-benefit plan (Table 2).[5] Beneficiaries may have multiple limited benefit plans with different plans for Medicaid behavioral health benefits, oral health benefits, and LTSS.

Enrollment varies by the type of benefit offered under a limited-benefit plan. In 2011, many beneficiaries were enrolled for purposes of receiving oral health benefits. This was followed closely by behavioral health.

Table 2. Full-Benefit Dually Eligible Beneficiary Enrollment in Limited-Benefit Medicaid Managed Care by Type of Benefit, 2011

Medicare	Limited-benefit Medicaid managed care[1]									
	Oral health benefits	Percent of total	Behavioral health benefits	Percent of total	LTSS	Percent of total	Other benefits	Percent of total	Total Enrollment[2]	Percent of total
Total	1,516,020	34%	1,488,796	34%	147,605	3%	1,246,091	28%	4,398,512	100%
FFS	1,073,285	34	964,067	31	90,220	3	1,006,389	32	3,133,961	71
Medicare Advantage[3]	261,399	36	293,660	40	32,959	5	140,131	19	728,149	17
D-SNP	172,982	35	224,832	45	22,505	5	78,519	16	498,838	11
I-SNP	3,027	23	5,463	42	1,864	14	2,677	21	13,031	0
C-SNP	5,327	22	774	3	*	0	18,375	75	24,533	1

Notes: D-SNP is dual-eligible special needs plan. C-SNP is chronic condition special needs plan. I-SNP is institutional special needs plan. FFS is fee for service. LTSS is long-term services and supports. An individual can be enrolled in more than one limited-benefit plan. Total enrollment in limited-benefit managed care refers to the total number of dually eligible beneficiaries that are enrolled in at least one limited-benefit plan. Individuals enrolled in a Section 1876 cost plan, an employer or union sponsored Part D retiree plan, a continuing care retirement community demonstration, end-stage renal disease managed care demonstration, or who have missing or unknown Medicare enrollment are not included in the table. Dually eligible individuals included within this analysis are those with at least one month of dually eligible enrollment during the year, which is referred to as an ever-enrolled count. Partial-benefit dually eligible beneficiaries are excluded along with enrollees in the Program of All-Inclusive Care for the Elderly. Enrollment in the territories is not included.
* Indicates less than 100.
[1] This table includes dually eligible beneficiaries enrolled in limited-benefit plans, including those with and without comprehensive Medicaid managed care.
[2] This total includes duplicative counts of individuals enrolled in more than one limited-benefit Medicaid managed care plan.
[3] Medicare Advantage plans include coordinated care plans (i.e., health maintenance organizations, and local and regional preferred provider organizations), Medicare Advantage private FFS plans, and Medicare medical savings account plans.
Source: Acumen LLC analysis of Medicaid and Medicare enrollment and claims data for MACPAC.

Enrollment in limited-benefit plans varies by state. Most of the 4.4 million enrollees were in California, Michigan, New Jersey, or Pennsylvania. Those four states accounted for more than half (56 percent) of all full-benefit dually eligible beneficiaries enrolled in limited-benefit plans.

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Enrollment also varies by type of benefit. Almost all (93 percent) enrollees receiving oral health benefits through a limited-benefit plan were in California. For behavioral health benefits, the states with the highest enrollment in limited-benefit plans were Arizona, Michigan, Pennsylvania, Tennessee, and Washington. Together these five states accounted for over 70 percent of all enrollees receiving behavioral health services through limited-benefit plans. The states with the highest enrollment in limited-benefit plans for LTSS were Arizona, New Mexico, New York, and Wisconsin. These states accounted for almost all enrollees receiving LTSS through limited-benefit plans.

Endnotes

[1] Limited-benefit Medicaid managed care plans can offer beneficiaries a specialized network of experts with experience managing specific health conditions for targeted populations, and they can focus on developing performance standards and monitoring quality of care for certain populations.

[2] Dually eligible beneficiaries who receive full Medicaid benefits are referred to as full-benefit dually eligible beneficiaries. Individuals who only receive assistance through the Medicare Savings Programs, and do not receive full Medicaid benefits, are referred to as partial-benefit dually eligible beneficiaries.

[3] The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) established the Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). FIDE SNPs are a special type of D-SNP designed to promote the full integration and coordination of Medicaid and Medicare benefits through a single managed care organization (CMS 2016a). Data on FIDE-SNPs were not available for this issue brief.

[4] Section 1876 cost plans are plans operated by a health maintenance organization or competitive medical plan in accordance with a cost reimbursement contract under section 1876 of the Act and Title 42, Part 417 of the Code of Federal Regulations.

[5] The 4.4 million enrollees with at least one limited-benefit plan represent a duplicated count of enrollment with individuals enrolled in more than one limited-benefit plan (Table 2). An unduplicated count shows that about 4.0 million beneficiaries were enrolled in limited-benefit plans (Table 1). The difference between the duplicated and unduplicated counts, or about 400,000 dually eligible beneficiaries, most likely represents enrollees with more than one limited-benefit plan.

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Appendix: Data Sources and Methodology

These data cover calendar year 2011compiled specifically for the joint MACPAC and Medicaid Payment Advisory Commission (MedPAC) 2016 *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* by Acumen, LLC. Sources include Medicare enrollment data from the Enrollment Database and Common Medicare Environment (CME) files, Medicare Part A, Part B, and Part D claims from the Common Working File and Part D prescription drug event data, Medicare Part C payment data from Medicare Advantage Prescription Drug files, and Medicaid enrollment and claims data from Medicaid Statistical Information System (MSIS) files.

These files are similar to files created for research purposes by the Centers for Medicare & Medicaid Services (CMS), such as the Medicare–-Medicaid Linked Enrollee Analytic Data Source. However, differences in the methodology for creating analytic files (such as the incorporation of revised MSIS data submitted by states that may not always be reflected in the research files from CMS) may lead to estimates of enrollment and spending that are slightly different from other analyses that use CMS research files. Regardless of which versions are used, differences in how analytic populations are defined (such as counting dually eligible beneficiaries using an ever enrolled rather than an average monthly or point-in-time measure) may also explain differences between the estimates presented here and those published elsewhere by MedPAC, MACPAC, CMS, and others.

Each Medicaid and Medicare beneficiary represented in these datasets was assigned a unique identification number using an algorithm that incorporates program-specific identifiers (such as Health Insurance Claim numbers for Medicare and MSIS IDs for Medicaid) and beneficiary characteristics (such as date of birth and gender). This unique ID was used to link an individual's records across all data sources, including both Medicare and Medicaid files for dually eligible beneficiaries, and to create unduplicated beneficiary counts. Although dually eligible beneficiaries may be identified in several ways, the MACPAC-MedPAC joint data book uses the dually eligible indicators in Medicare CME data derived from state-submitted Medicare Modernization Act files. Results may differ slightly from analyses that use other data sources (such as MSIS) for this purpose. In our analysis, the dually eligible beneficiary population consists of individuals with at least one month of dually eligible enrollment during the year. Non-dual Medicaid and Medicare beneficiaries were identified as individuals with zero months of dually eligible enrollment during the year (MedPAC and MACPAC 2016).

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